MaineCare Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Summary of Questions
Behavioral Health Home Request for Applications
November 21, 2013

Primary Care practices/Partnerships	
1. Do BHHOs need to have agreements/MOUs with practices in place before the application is submitted or can this be done before April 1st?	Behavioral health organizations do not need to identify their partnering practices with the application. However, BHHOs must identify at least one partnering practice along with their confirmation status by January 10, 2013, and must have a Memorandum of Understanding (MOU) in place by April 1, 2013 in order to begin providing services. Additional primary care practices should be identified prior to March 1, 2014 if those practices would like to have members enrolled and receive payment beginning in April, 2014.
2. It looks as if the Letter of Intent form is set up for either a Behavioral Health application or a PCP looking to partner but the actual application form is strictly for the BHHO and you need to identify at least 1 PCP partner in the application – correct?	Correct.
3. Is there an application	Yes: the application for new practices interested in participating in Health Homes will be

process for a Primary Care practice interested in becoming a Health Home Practice?	released on December 2, 2013.
4. How will participating PCPs be able to identify their Stage B members in order to collect the $15 PMPM?	PCPs will use the online Health Home Enrollment System to identify members and attest that they have performed the minimum billable service to receive payment.
5. On page 4, it states that "MaineCare currently has 159 Health Home practice sites". Does this refer to the Quality Counts pilot sites, which are a mix of PCMH and HH Stage A sites?	Yes: all of these practices are approved to participate in the MaineCare Health Home initiative.
6. Under Paragraph 8 of this section, will MaineCare commit to providing a template MOU/Agreement between HHPs and BHHs to share a starting place for discussions? Is there a template that has	Yes, Mainecare will provide a template for the MOU. This application will be available after the application due date.

<table>
<tr><td>worked well in Stage A that can be customized for BHHs that can be shared? If so, can such a template be shared before the Application Due Date?</td><td></td></tr>
<tr><td>7. What does the Department mean when it states that the PCP and BHHO shall “partner”?</td><td>MaineCare expects that the BHHO and the HHP will enter into a memorandum of understanding or agreement that describes procedures and protocols for regular and systematized communication and collaboration across the two agencies and other information necessary to effectively deliver BHH services to members, including:
Names and contact information of key staff at BHHO and HHP
Procedures for effective communication, such as
Acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information
Frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly)
Procedures for Bi-directional access to member plan of care and other health information;
Referral protocols for new members;
Collaboration on treatment plans and member goals;
As needed, Business Associate Agreement/Qualified Service Organization addenda.</td></tr>
<tr><td colspan="2">Team Structure/Staff</td></tr>
<tr><td>8. Are there minimum FTE expectations for the required team members/components ?</td><td><table><tr><th>Staff</th><th>FTE per 200 members</th></tr><tr><td>Clinical Team Leader</td><td>0.75</td></tr></table></td></tr>
</table>

	HH Coordinator	7 (children) 8 (Adults)
	Peer Specialist	1
	Nurse Care Manager	Child: 0.50 Adult: .75
	Medical Consultant	0.02
	Psychiatrist	0.02
9. What is the minimum licensing/credentialing or experiential requirements for BHHO staff delivering services to members?	Please refer to Appendix A.	
10. Do we need to have all of the Health Home roles assigned to individuals before applying?	It is not necessary to have all staff assigned their BHH roles prior to applying. However, organizations should have the teams in place before implementation	
11. Does the Behavioral Health team need to reside on site at each location, or can one team serve multiple locations?	Teams can serve multiple locations as long as they are able to meet the minimum requirements for the service, and meet the needs and service location preferences of their MaineCare members.	

12. Please expound on the medication management requirement	Medication management is not a covered service under Behavioral Health Homes: these services are billable under applicable sections of the MaineCare Benefits Manual. Psychiatric Consultation is a part of the BHHO team, and is intended to provide the team and the organization with access to psychiatric consultation on best practices standards in integrating care, and consultation as needed to the team and to the primary care partner.
13. In identifying the credentials for staff, the MHRT certification is listed. This is the certification for those working with adults with serious mental illness under DHHS funding. The certification for those working with children is the Behavioral Health Professional (BHP). Would this be more appropriate for those BHH Providers who have children with severe emotional disturbances?	Separate and distinct credentials for BHHOs serving children with SED are delineated in Appendix A. The BHP credential is for services delivered under Home and Community Treatment and will not be used for BHHO staff.
14. Do all positions need to be FTE or based on the	They can be prorated based on the number of members served.

population served?	
15. Will assumptions for the staffing ratios be included in the MaineCare Rule?	The Mainecare rule is still being drafted, and it is not yet determined whether this will be included in the language.
16. The RFA states that the team will consist of "Nurse Care Manager" with a wide variety of levels of expertise/credentials and "Primary Care Consultation" with no listed requirements of expertise/credentials. Please differentiate the different services/tasks MaineCare envisions each of these team members providing as well as the intended credentials for the team member entitled "Primary Care Consultation".	The nurse care manager will be an integral part of the team, assisting the team in developing and implementing plans of care for members. The primary care consultant is intended to provide the team and the organization with access to medical consultation on best practices standards in integrating care, and consultation as needed to the team. Please see Appendix A for additional information on credentialing.
17. Can you provide more information about what a "Certified	Providers wishing to provide BHH services for adults will need to include a CIPPS-certified Peer Specialist on their team. For more information on the requirements for this certification, please go to

Intentional Support Specialist" is, how that certification is obtained, and how a provider would locate peer support specialists with that certification? Will there be a requirement for this certification or any specific peer support training for a peer to serve as the Peer Support Specialist in the BHH team?	http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/intentional_peer.shtml
18. If "team" members can be included without being employed by the BHH what specific agreements or contracts are required to meet the Department's criteria?	Organizations must ensure that all members of the team are properly licensed, certified, and supervised to provide designated services.
Members with intellectual/developmental disability	
19. Will any individuals with ID/DD who receive TCM now be	Individuals who have co-occurring ID/DD and serious emotional disturbance/ serious mental illness may choose to receive BHH services. However, these individuals will no longer be able to receive Targeted Case Management (TCM) or Section 17 Community Integration (17.04-1)

eligible for BHH services?	services.
20. Children who have a primary diagnosis of autism/ID, but also a Mental Health diagnosis, will be assigned to a behavioral health home. Can children like this be in stage B? Are children with Autism alone only allowed in Stage A? Will the care coordinator be responsible for writing the PCP plan that is required under ID CCM?	Children with autism may be enrolled in the BHH if they meet diagnostic and functional eligibility criteria. Children with autism are also eligible for services in Stage A. BHH are responsible for delivery of services as described in the State plan Amendment and MaineCare regulation. The BHH SPA and MaineCare regulation will not incorporate requirements from ID/DD services.
21. Can kids with Autism (or on the spectrum) be enrolled in Behavioral Health Homes?	Children with autism may be enrolled in the BHH if they meet diagnostic and functional eligibility criteria.
22. If a client is getting Community Case	No, only children Behavioral Health TCM or adults receiving Sec 17 Community Integration (17.04-1) and whose current TCM or CI provider is participating in BHH will be automatically

Management (ID services) and they are also accessing section 17 Skills Development services do they automatically get enrolled in a BHH? How will this work if they are accessing waivered services under ID services such as section 29 and also accessing Section 17 skills development. A client has to have a CCM to get waivered services.	enrolled. Members receiving other case management services (TCM/CCM) will not be automatically enrolled, but may elect to participate if they meet eligibility criteria. However, they will no longer be able to receive TCM/CCM if enrolled in the BHH.
23. Will the client have to end section 17 services in order to keep CCM and waivered services?	Mainecare members receiving CCM/ID services will not be automatically enrolled. If they are eligible for BHH services, they can choose to participate, but they would no longer receive TCM/CCM or Section 17.04-1 (Community Integration) services. They may receive other Section 17 services that do not duplicate BHH services.
Role of APS	
24. What role will APS play – will clients be approved for the BHHO in APS?	Yes, members will be prior authorized for Behavioral Health Home services via the APS process.

25. The RFA discusses "periodic review" of the comprehensive plan of care/person-centered plan in several places. What is the MaineCare's desired schedule of such a periodic review, and will there be templates provided for those reviews?	The Plan of care will be revisited and reviewed by the BHHO and the member every 90 days. There is no plan to develop a template at this time, but guidance will be provided.
26. What reporting requirements will continue or potentially change with regard to APS and what will the frequency of APS reporting requirements be? Is this the quarterly Quality Improvement reports referred to in the RFA?	Providers for adults will still be required to submit the ISP every 90 days and comply with consent-decree related reporting. The quarterly reporting is a separate requirement: this is a self-assessment that identifies progress toward implementation of Core expectations and BHHO functional components, and is used both to track progress and identify training needs as a part of the Learning Collaborative.

27. Given the expectations for the BHH services, please explain why APS will continue to have a role in the management?	APS will continue to assist in tracking information relevant to SAMHS for the BHH-eligible population, and will also assist in PA and continuing stay review. APS will continue to assist DHHS in ensuring that the member is receiving services at the right level and in the right amount.
Eligibility	
28. Is MaineCare able to describe in detail its interpretation of the Federal definition of "serious emotional disturbance" for children?	MaineCare is in the process of revising its Children's BH TCM criteria to incorporate the DSM V and the CANS assessment tool. Behavioral Health Homes will align with this definition of children with serious emotional disturbance. Draft eligibility criteria for BHH is as follows: Serious Emotional Disturbance. Children members must meet the following criteria. Eligibility must be supported by written diagnosis(es), rendered by a physician, a physician assistant, or an independently licensed clinician, within the scope of the professional's license, and the diagnosis(es) shall be documented in the member's Plan of Care: 1. Members must have received an Axis I or Axis II mental health diagnosis(es) as described in the Diagnostic and Statistical Manual of Mental Disorders IV, or a mental health diagnosis under the Diagnostic and Statistical Manual of Mental Disorders V, or a diagnosis described in the current version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood (DC:0-3), except that the following diagnoses are not eligible for services in this section: (a) Learning Disabilities in reading, mathematics, written expression; (b) Motor Skills Disorder; (c) Learning Disabilities Not Otherwise Specified;

	(d) Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder Not Otherwise Specified; AND Members must also have a significant impairment or limitation in adaptive behavior or functioning according to a standardized tool: a. CAFAS: the eight (8) scale composite CAFAS score is at least fifty-one (51) b. CANS: assessment scores indicate a 2 or higher in both of the following sections: "Child Behavioral/Emotional Needs" AND "Life Domain Functioning". c. The PECFAS and/or ASQ: SE: these tools indicate possible functional impairment(s) and together with other clinical information a comprehensive view of the child is developed and the need for case management services is identified.
29. Is it anticipated that any person who fits the basic eligibility requirements set forth would otherwise be excluded for any other reason for participating in the health homes and what are those possible reasons?	Members may be excluded because they wish to retain other services that duplicate BHH, such as TCM, Community Integration, or Stage A Health Home services, or because they wish to retain a PCP that is not participating in the program. These members may retain their current services. Members may also be excluded due to not having full MaineCare benefits.
Enrollment/Notification/Choice	
30. Please clarify the	Members who are receiving BH TCM or Community Integration 17.04-1 from a participating

process of enrolling a member in a BHH.	BHHO will be enrolled as BHH members at that organization (or site). Members will receive an "opt out" letter that explains the service. These members can choose to enroll, opt out of the service, or choose to go to a new or different BHH site.
31. It appears the starting point will be to offer enrollment to those already in programs such as TCM or Section 17 - Community Integration, but how will members who are newly qualified be connected with agencies going forward?	Members who have never received TCM or CI services may, after being determined eligible for the service, choose to go to any BHHO in their area. MaineCare will also send a notification to members who may be eligible, letting them know about the service and providers in their area.
32. How will members opt out?	The opt out letter described will provide members with a MaineCare number to call if they do not want to be enrolled. Members who want to opt-out will remain in TCM or CI services.
33. Is there a limit to how often and when people can opt in/opt out?	No.
34. Can agencies help patients who seem to meet criteria, apply for BHH services, and what	Organizations can assist patients who may be eligible in accessing the service; members will need to go through the APS PA process to determine eligibility.

would that process be?	
35. The RFA states "[i]f the member is no longer in need of the BHHO level of service, the member may receive services solely from the HPP. In those instances, only the HHP receives a PMPM payment." What entity will determine that a member is no longer I need of a BHHO level of service?	Detail on service design is subject to change due to CMS review, and the review of the Office of the Attorney General. Because concerns have been raised about the legality of the "step-down" feature, MaineCare has decided to eliminate this from the design.
36. Can you provide the referral and enrollment process planned for MaineCare members assigned to a particular Accountable Care Community, that have not before received TCM or CI services, and how choice of providers will be	The process for members new to the service will be similar to how any MaineCare member currently accesses behavioral health services. MaineCare Accountable Communities are not gatekeeper organizations and may not limit member choice of providers.

maintained regardless of whether a particular BHH provider is part of an ACC?	
37. If an agency provides both TCM and pilots BHH in one office, does a letter get sent to all members served by the agency or just those associated to the BHH? Would members at other sites choosing not to pilot it receive the letter?	Members receiving services at the BHH location will be enrolled at that location and receive notification. As required by CMS, members that are eligible for the service but not enrolled (for instance, members at other locations/agencies not offering BHH) must receive written notification of their eligibility for the service, and the locations in their area where these services are available.
38. What methods and how far in advance of the implementation date will members be notified of this new service and the choice they need to make?	Mainecare is planning to notify members of the service and enrollment in mid-February. Providers will be notified of the content and timing of this letter.

39. Original MaineCare presentations re: BHH's led one to believe that all members receiving TCM or CI at the time of BHH implementation would be enrolled in a BHH, and they would need to consciously OPT OUT, if they did not want BHH services. Has that changed? The RFA language leads one to believe that it is now an OPT IN process: "Participation in Behavioral Health Home services is entirely voluntary. Members may choose to receive BHH services, or may remain with their current services….."	As discussed, only members receiving Children's BH TCM or 17.04-1 CI services at participating organizations/sites will be automatically enrolled. These members will need to opt-out if they do not wish to participate.
40. Is it expected that individuals will not have a choice about enrolling in a BHH at some point?	There is no expectation that choice will be limited.

41. What is the plan for communication with consumers and parents?	MaineCare has been working with OCFS and SAMHS in identifying and leveraging opportunities to connect with consumer and family organizations in order to provide education and information on the Behavioral Health Home model, and this work will continue. In addition, MaineCare will be partnering with consumer organizations to assist in development of member outreach and education materials. More directly, participating agencies will also be expected to reach out and provide materials to their members in advance of implementation.
Impact on other services	
42. Can you provide both BHH services and traditional section 17 services?	Yes; however, members may not receive both BHH and Community Integration (17.04-1) or TCM at the same time as this will be deemed a duplication.
43. Can a member receive case management services outside of the Behavioral Health Home?	No, but the member has a choice of services and may choose to receive TCM or Community Integration instead of BHH services.
44. Will section 28 services be separately billable?	Yes.
45. In the long term is it the Department's intent to discontinue TCM and ACIS services?	There is no intent or plan to discontinue these services.
Billing/reimbursement	
46. What is the time frame to deliver "at least one	Per month.

documented hour of BHH services" - is this per month or per some other time segment?	
47. How will we bill this?	Billing will be monthly based on the number of members served as identified by the provider in the Health Home Enrollment Portal. Providers will receive payment via EFT (Electronic Fund Transfer) or check. Payment information will appear on Remittance Advice (RA).
48. Will there be flex funds similar to Stage a HH?	MaineCare does not provide flex funding to providers under Stage A. As in Stage A, providers will receive a PMPM payment.
49. Will service provider tax be applicable to the BHH care coordination as it is with CIS?	This is under review.
50. If member enters or exits on the 15th of the month, will PMPM for month be paid?	As in Stage A, MaineCare anticipates that providers will be paid based on a snapshot of members enrolled in the program on the 21st of the month.
51. What is 'scanning for gaps in care"?	"Scanning for gaps in care" means that the Health Home practice is using population-based systems and procedures, such as patient registries, to monitor patient needs. MaineCare has developed the Health Home Utilization report to assist practices in scanning for gaps in care using the most recent MaineCare claims data to identify members with ER use, hospital admissions, polypharmacy, and other key utilization indicators. Practices have access to this information for all members of their Health Home practice, and scanning this data on a monthly basis to identify care needs is an example of scanning for gaps in care.
52. The RFA states that "The State will review rates to ensure that	MaineCare will be gathering data throughout the initial two years of the BHH implementation to determine the adequacy of rates and identify any changes necessary to support the service economically and efficiently. In particular, Mainecare will be reviewing rates and service

rates are economic and efficient. MaineCare will continue to base payments on the costs of staff to provide the BHH services to eligible MaineCare members." How often will the rates and the adequacy of such be reviewed?	utilization to determine the adequacy of the rate structure in serving both high and lower needs members. Any rate changes would need to be done via a State Plan Amendment.
53. What factors has/will the disparities in service delivery capacity in rural/frontier areas play in determining the rates?	MaineCare reviewed average per member per month cost and utilization across all organizations delivering community integration and/or TCM services. Although there were significant differences in the PMPM cost based on agency, these differences did not appear to be driven by location in a rural/frontier area.
54. What rates, for what disciplines, and in what geographic area were used to develop the current PMPM rates?	Costs were developed based on Bureau of Labor Statistics for the State of Maine, and include 30% fringe and 30% indirect costs. Please see the cost assumptions document posted at the BHH website: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/HH/Behavorial%20HH/BHHratesandstaffingassumptionsNov2013.xls
55. How did the rate setting methodology factor in the cost of serving high-needs members?	MaineCare developed the cost assumptions for the service, including proposed staffing, indirect, and fringe costs. Mainecare then reviewed current average PMPM cost (based on utilization/claims data) across all CI and TCM agencies. These utilization averages (adults/children) were further adjusted after discussion with provider organizations by removing members with low utilization (this represented the low end utilization for

	approximately 26% of members).
56. With regard to the $35.00 PMPM for the first six months regarding outreach, education and enrollment efforts, please provide the methodology for the calculation of the rate, including assumptions about which position will perform the specific responsibilities, the number of hours per month each position named above will complete this work per client, and assumptions on how much time MaineCare determined will be necessary per month per client for outreach, education and enrollment.	The $35.00 PMPM is subject to approval from CMS; MaineCare anticipates that this payment will be provided during the first three months as opposed to six months. This add-on payment reflects recognition by MaineCare that initial engagement activities, including education to and coordination with the member regarding primary care, may require additional staff/team time. MaineCare estimates this additional staff cost at 10-15% of team time per member.
57. Will the MaineCare rules identify a	MaineCare rules are still being drafted, but it is not anticipated that the rule will include a maximum caseload.

maximum # of members per care manager (caseload maximums)?	
58. Will outpatient therapy services continue to be reimbursed on a fee for service basis and separated from BHHO core services?	Yes.
59. Can medical practices that are included in the BHH bill for medical services – in addition to the $15PMPM fee?	Yes
60. What are the services that are to be included in the PMPM fee? What can be billed to the client in excess of the fee (transportation, ED visits, specialty care)	Services included in the PMPM fee structure are described in Part V of the RFA. These services are Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and family Support, and Referral. Other services, such as transportation, ED visits, therapy, etc. would be billed to MaineCare outside of the BHH PMPM rate, as per the applicable Mainecare Benefits Manual section.
61. Do rate costs include consideration for consultation and collaborative work needed for individual	Yes. Rates do not require a specific face-to-face service but can include collateral contact, phone consultation, and team meeting time.

consumers and for development of effective relationships between provider entities?	
62. What are the specific criteria for BHHO to be reimbursed for services to a consumer? Is it based on an encounter and would this be face to face and must it be with the consumer?	The BHHO must deliver at least one hour of service per month to the enrolled consumer. Services may be delivered in an office, home, or community setting. Services may be delivered face-to-face, via phone, secure email or other means, or in a group setting. Services include collateral contact with members of the treatment team or other providers/supports. Unless otherwise noted, specific services and how they are delivered (and by whom) shall depend on the needs identified in the member's plan of care. Services shall be documented in the member's record.
Provider participation	
63. Can an agency with no prior experience with Targeted Case Management apply to have BHH services for children?	Yes; however agencies must be licensed to provide Community Mental Health Services, have a contract to deliver Children's Behavioral Health Services with the Office of Child and Family Services, and be a participating MaineCare provider.
64. Will it be a separate portal or the same as HHP?	The same portal as for Stage A Health Homes.
65. If an agency applies for	Yes; however Mainecare will require notice and time to transition members to other services

and is accepted for enrollment as a BHH, but cannot enroll enough members to make the program financially effective– can the agency terminate the contract?	as per MBM Chapter I.
66. The BHH application asks to indicate whether "Our organization is licensed to provide Community Integration services to adults." It is our understanding that Community Integration is included under Community Support Services. We have a full license to operate a Mental Health Agency to provide Community Support Services. Does that make our organization eligible to become a BHHO?	Yes, organizations must have the appropriate community Mental Health license prior to implementation of the BHH. This licensure must be specific for the site and the type of service to be delivered; new mental health licenses or additions to existing licenses require a site visit that can take approximately 30 days to schedule. Please consult directly with DLRS in order to determine exactly what your organization may need. Organizations must also have a contract with either the Substance Abuse and Mental Health Services, or with the office of Child and Family Services to provide mental health services to children and/or adults.
67. Can an organization be a Stage B primary care	Yes.

health home and a BHHO and receive PMPM reimbursement for both?	
Provider communication/outreach	
68. What is the plan for provider engagement in terms of frequency, method and goals for engagement with providers? Considering the enormity of this change in service delivery and reimbursement, it would be helpful if DHHS did not limit the #'s of individuals that can attend its presentations/forums/ listening sessions. For larger organizations, there are often multiple individuals directly involved with new initiatives who would all benefit from hearing/learning first	Mainecare, via the State Innovation Model, will be contracting with Maine Quality Counts to provide a learning collaborative for BHH providers to assist in implementation, refinement of the model, quality improvement, and technical assistance. The Learning Collaborative will provide learning opportunities and other supports to participating providers and their designated leadership teams. Due to limited resources, participation in the learning collaborative activities may be limited to identified teams from each BHHO.

hand due to their varying perspectives/roles.	
69. Which specific offices or entities within the Department will be managing the contracts with BHH providers?	Contracts will be managed by OCFS and SAMHS.
70. What if any additional contractual terms or requirements will exist in addition to MaineCare regulatory and federal regulatory requirements?	Providers that plan to provide BHH services for adults will be required to complete a SAMHS BHH contract. Providers of BHH services for children will operate these services under existing OCFS children's behavioral health contracts.
State Plan Amendment and Mainecare Regulation	
71. What is DHHS's anticipated submission date for the SPA to CMS?	MaineCare anticipates SPA submission to CMS in early December, 2013.
72. What is DHHS's anticipated timeline for receiving a response/approval for the SPA from CMS?	MaineCare's Stage A SPA was approved within 90 days. However, we cannot control the CMS approval timeline.
73. Does DHHS intend to begin implementation of Behavioral Health	Yes, if necessary.

Homes before receiving approval from CMS?	
74. If CMS does not approve the SPA in the form it is submitted, what delay will that cause to the implementation of Behavioral Health Homes? Is there a Plan B for the model and for communications with both consumers and providers?	Unlike other SPA processes, CMS encourages states to work with CMS upfront, prior to SPA submission. MaineCare and CMS have been in discussion with CMS about the SPA and hope to identify and resolve any issues prior to submission.
75. By what date does MaineCare envision having all related BHH rules in place in the MaineCare Benefits Manual?	Mainecare will propose the BHH rule in December and plans to have the BHH rule in place by April 1, 2014.
Core Expectations and Clinical Requirements	
76. Under Core Expectations, what is "Population Risk Stratification and Management"?	Population risk stratification and management refers to processes for proactively identifying and assessing individuals across the practice population who may be at risk for adverse outcomes, and then directing resources or care/care coordination processes to help reduce those risks.

77. Population risk stratification and management: Behavioral health homes do not typically have experience in this area. What specific guidance, tools and training does MaineCare intend to share/develop with and for providers prior to the Application Deadline of December 6, 2013?	MaineCare expects providers to be working toward achievement of the core expectations during the first year of BHH participation. MaineCare will provide support to providers on this and other core expectations via the Learning Collaborative. This will not be prior to the application deadline, however.
78. What will be the process for notification to a provider that it is not meeting a particular Core Expectation Benchmark?	Core expectations will be tracked via quarterly reporting as part of Learning Collaborative activities. Providers will do self-assessment and work with QI specialists to identify actions plans to address problem areas. Providers must meet core expectations within one year of BHH participation, or risk being terminated from the program. MaineCare will notify providers in writing.
79. What entity will be responsible for the review of provider performance with regard to meeting Core	Maine Quality Counts will support providers in working toward implementation of the core expectations, and will monitor quarterly self-assessment on progress toward these goals. However, MaineCare is ultimately responsible for determining compliance with the rule, including core expectations.

Expectation Benchmarks?	
80. Under Paragraph 6 of this section, are all of the core functional components listed A-K expected to be in place on Day 1 of implementation (April 1, 2014), and if not, what are the specific expectations for each lettered component in that section?	The functional components will also be part of the quarterly review process. These components must be in place within 18 months of implementation. In addition, Mainecare anticipates that all BHHO providers will be working toward the adoption of an EHR if they do not have that capacity on day one, and in the interim should be able to send and receive encrypted email in order to share PHI among treating providers.
81. Under Paragraph 6 of this section, letter I refers specifically to a patient-centered care plan. Will MaineCare commit to providing a template of the care plan it envisions for this purpose to providers before Day 1 of Implementation?	MaineCare rule will provide guidance on the components of an integrated plan of care prior to implementation.
82. Under Paragraph 6 of this section, letter K refers to establishing a "continuous quality	MaineCare will establish a quality framework that collects and tracks data across the BHH initiative on a number of measures (see BHH RFA, section VII). However, each BHHO organization must also establish internal CQI processes that enable them to track and evaluate their BHHO efforts. The BHH Learning Collaborative may provide additional and

improvement (CQI) program", and collecting and reporting on data that "permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality care outcomes at the population level." Will MaineCare commit to providing a "road map" of sorts that provides an example of the types of data collection, reporting and evaluation of both individual-level clinical outcomes and quality care outcomes at the population level required?	technical assistance for these activities.
83. Inclusion of patients & families in implementation of BHH	Examples of this Core Expectation include: • processes in place to support members and families to participate in leadership and/or advisory activities;

model. Please provide an example of what MaineCare envisions with this core expectation, considering that patients and families are already at the core of planning and delivery of case and care management services?	• implementation of systems to gather member and family input at least annually (through mail surveys, phone surveys, point of care questionnaires, focus groups, or other methods); and • Processes in place to design and implement changes that address needs and gaps in care identified via member and family input.
84. Commitment to reducing waste and unnecessary health care spending. We can all agree on the importance of this core expectation, but can MaineCare provide examples (other than reduced hospital admissions and reduced unnecessary ER visits/diagnostic testing/prescriptions) of how it envisions	Out of home placement is another significant cost driver for children that could be the focus of cost reduction, as appropriate.

BHHs impacting this expectation for children?	
85. The RFA states "the organizations will provide integrated and coordinated BHH services, including the method for regular and systematic provider to provider communications, sharing patient information securely across organizations; and timely collaboration in comprehensive person-centered care management and plan development." Is there a best practice in terms of the method, frequency and manner of communications between HHPs and BHHs that MaineCare will share prior to Day 1 of Implementation?	These issues will need to be addressed via communication and agreement between the BHHO and HHP partners. In Stage A, MaineCare indicated that communication between these entities occur at least monthly.

86. The RFA describes features of a Health Home that differentiate it from case management services, including "Population-based: tools, such as patient registries, are used to identify needs across the member panel." Does MaineCare intend to provide a template for a patient registry that will be most effective for a Behavioral Health Home?	MaineCare expects that providers will be supported in these and related issues via the BHHO Learning Collaborative.
87. Other than the CAFAS and the CANS listed as eligibility assessments for children with SED, what tools will MaineCare recommend or require BHH's utilize to assess for "medical, behavioral, social, residential, educational, vocational and other related	MaineCare is not recommending or requiring specific tools be used in this assessment but leaves this to the clinical discretion of provider agencies. The assessment upon which the plan of care is based is rolled into the PMPM. For adults, assessment of all of these domain areas every 90 days is a requirement of the Consent Decree and ISP planning process.

strengths and needs?" Is the assessment requirement rolled in under the PMPM reimbursement if the person is eligible and elects to enroll in the BHH?	
88. Please clarify as to whether the state is seeking to have a case/care management focus or an approach similar to an ACT team that includes most of the direct care services.	Mainecare is focusing on enhancing current case management/CI capacity, and does not expect the BHHO to provide direct services beyond those listed as covered services in the RFA.
Documentation/Compliance	
89. The RFA states "[s]ervices shall be documented in the member's record." In most cases, the Behavioral Health Home will have its own record keeping system or EMR, and the HHP will have its own system as well. Even	Each organization is expected to maintain its own record to document service delivery and compliance with MaineCare rules and regulations.

with linkages to HealthInfoNet and the use of secure e-mail, neither record will necessarily be complete. Which record does MaineCare envision as "the member's record"?	
90. In sub-section E, Application Review & Eligibility Notification, you state that MaineCare must receive and have on file a Commitment Letter signed by the authorized representative of the approved organization. What are the terms and conditions that are required in the Commitment Letter?	The commitment letter is signed by the organization's authorized representative and states that the organization shall participate in the BHH services as of April 1, 2013. The terms and conditions for participation will be encompassed in Mainecare regulation. Once that commitment by the authorized representative has been received, MaineCare will begin the process of identifying and notifying the organization's members.
91. From the Stage A initiative, what is the average documentation time per client per month for Health	MaineCare has not tracked this information.

Homes? For CCT's?	
Service Definitions	
92. Under Comprehensive Care Management: The RFA discusses the "intensive and individualized outreach, education and support to the member (and family, as appropriate) regarding BHH services and benefits…." Is MaineCare going to develop the educational materials regarding BHH's that it intends for this purpose, particularly regarding benefits of a BHH and information sharing of PHI? If so, when will those materials be available?	Mainecare does intend to develop some informational materials as a part of the roll out of BHH. Materials will be available prior to member notification in February, 2014.
93. Under Health Promotion: The RFA	No, MaineCare will not be developing these tools although the Learning Collaborative will provide guidance and information to providers on these kinds of practice improvement

includes "population-based strategies (such as the use of disease registries) that enable systematic engagement and outreach to members about services needed for both preventive and chronic care" as one of the services required of a BHH. Is MaineCare going to develop the population health management tools for BHH's? If so, when will they be available?	issues.
94. Under Comprehensive Transitional Care Services: All of the bulleted points within this section are clear about the BHH's responsibility to work with different types of healthcare facilities to create smooth	While these issues do have applicability to the role of the BHHO in Maine's system of care for children, this question is outside the scope of this Q&A, which pertains to the BHHO RFA.

transitions to lower levels of care, create continuity in care and follow-up post-discharge, etc…. Currently, with regard to children, there is a back log who meet the level of care for various services, but cannot be admitted because there are no open beds, or the community supports needed for safety are not there. What systems changes does DHHS envision that will enable these discharges and create availability of lower level placements so that a BHH can be most effective?	
Quality and Reporting Framework	
95. In Goal 1, Reduce Inefficient Healthcare Spending, "Percentage of Members with Fragmented Primary	Although connection to primary care is required, MaineCare is still interested in identifying fragmentation of care, indicated in this measure by the number of different providers visited, the proportion of attended visits to each provider, and the total number of visits.

Care" is identified as a potential indicator for measurement. If the BHH has a HH practice affiliation and connection with a primary care provider is required, how necessary and valid is this indicator?	
96. Can MaineCare commit to providing the final details on its Quality Framework and measures before the December 6th BHH application due date to give providers the ability to determine if their systems will be able to meet the goals?	Yes, MaineCare will post quality measures prior to the application due date.
97. With regard to "Goal 1: Reduce Inefficient Healthcare Spending" and the inclusion of "Out of Home Placement Days for Children" as part of that definition, how is	Number of behavioral health residential treatment bed days per member per month - (Breakout for adults 18 years and older and for children/youth – birth to 17 years)

DHHS defining "Out of Home Placement Days for Children"?	
98. Residential treatment programs are intentional placement options where both DHHS and families make a choice to admit a child who requires the highest level of medically necessary healthcare services available outside of hospitalization. Children's residential treatment is heavily managed by both DHHS and APS as a medically necessary Medicaid service and the designed efficiencies of informed and early discharge planning, continuous quality clinical reviews and the partnerships between providers, families and DHHS meet the needs	Understanding that residential placement is a necessary component in children's mental health services, it also represents the inability of the system to support that family and child in a less restrictive setting. To the extent that services and supports can be identified and coordinated to enable children to remain at home and in the community, additional costs incurred to provide residential placement can be seen as inefficient health care spending.

of each child within the allocated State resources. If DHHS defines "Out of Home Placement Days for Children" to include children's residential treatment, what is the rationale for including it under the heading of "Inefficient Healthcare Spending"?	
99. Under Goal 4: Promotion of Wellness and Prevention, why not include Smoking Prevention and Cessation Education for both Children and Adults?	Mainecare has attempted to limit BHH measures to those that can be supported via claims data or data that is already being collected in some manner. Smoking Prevention/Cessation is an example of a very important and applicable measure for this focus population. However, identifying, collecting and reporting on this measure (which would involve clinical data) is not feasible at this time. This would not prevent an organization from initiating and tracking a smoking cessation initiative as a part of its BHH health promotion activities.
100. Will there be indicators for Intellectual and Developmental Disabilities and what will those be?	No; the BHH initiative is focusing on integrating care for individuals with serious mental health needs.
101. Will	The list of measures will be posted to the BHH web page for review and feedback. In addition,

development of performance measures include involvement by consumers, parents and providers?	Mainecare will be participating in a broader behavioral health measures process via the State Innovation Model. Measures designed through this process will inform the next iteration of the quality framework.
102. Which data out of the Quality and Reporting Framework (page 11-12) will come from Mainecare and which will come from the reporting of individual BHHO's? For instance, will ED utilization come from MaineCare's data base or will it be through client self-report through a vehicle such as APS?	The quality measures, including detail on what data will be collected to calculate the measures, will be posted prior to the close of the application period. The intent in the selection of measures has been to align measures across initiatives to the extent possible (i.e., with Stage A Health Homes and Accountable Communities), to use nationally-recognized measures when possible, to minimize the reporting burden to providers by use of claims-based measures or existing reporting processes, and to select measures that can be impacted by the work of the BHH. Certain measures required by CMS do involve the use of clinical (EHR-derived) data, and MaineCare is working with Health InfoNet and others through the SIM process to identify how the data required for these measures will be collected.
103. Will there be quality forms developed by DHHS to be submitted in a monthly/quarterly basis – or do you expect agencies to	Agencies will submit quarterly self-reports to Maine Quality Counts that describe progress toward core expectations. The form will be provided.

develop their own data forms?	
Data and Health Information Technology	
104. Why is hospital data regarding IMDs and psychiatric specialty hospitals, and substance abuse-related detail from specialty substance abuse services excluded from the information that Behavioral Health Home providers will have access to?	MaineCare has excluded this information from the current data set for Stage A due to Maine's mental health confidentiality statute and the federal (42 CFR part 2) substance abuse confidentiality regulation. MaineCare will explore the possibility of expanding this data set to support BHH providers.
105. Will all of these data systems and access to them be available on Day 1 of Implementation of BHHs (April 1, 2014)?	That is MaineCare's intention.
106. Will MaineCare commit to work with all BHH providers and test the access to these systems before Day 1 of Implementation to	MaineCare and its vendor plan to test these systems prior to start up, yes.

assure a smooth start-up?	
107. What are the specific requirements for the components of an Electronic Health Record in terms of capacity, interoperability, and reporting? Agencies are in the process of developing systems and need clarification about system capacity, hardware and software standards, security system requirements and communication/interface/download system requirements. What specific financial and technical resources are available to support development, implementation and enhancement of IT efforts with BHHO's? How will BHHO's	MaineCare expects providers. At the end of the two-year period, to have implemented an EHR that supports Clinical EHR Functions, such as Intake, Clinical Care, Task Management, and case management where appropriate. The EHR should have HL7 interoperability capabilities with trigger events to support the electronic sharing of portions for the patient's record, for example: clinical assessments, care plans, continuity of care document (CCD).

access and interface with Health Info Net? Will there be support for providers in accessing HIN?	
Supports for Behavioral Health Home Providers	
108. The RFA states "MaineCare will develop BHH infrastructure through the following initiatives funded under the state's State Innovation Model (SIM) test" and lists three areas under development. With regard to "BHHO Health Information Technology" and the "limited number of behavioral health providers" that can receive funds to develop and adopt electronic health records, when will the criteria and application for those funds become available?	The criteria for the RFP process are being developed under the State Innovation Model Initiative; the RFP itself will be released by Health InfoNet and is slated for release in January. Mainecare is also working to identify additional resources to make available to providers who do not meet minimum RFP criteria.

109. With regard to "Workforce development", is there a national model of training/curriculum that MaineCare intends to use as the basis for its training?	MaineCare has not selected a curriculum, but plans to work with a vendor and stakeholders in the development or identification of a curriculum to enhance the capacity of mental health providers to deliver integrated services to eligible members.
110. Is MaineCare committing to providing the BHH curriculum to all BHH providers?	Yes.
111. Does MaineCare intend to develop a train the trainer program for the curriculum?	Mainecare has not yet identified the specifications for this work, which is being funded and developed under the SIM.
112. Will there initially, or later, be a cost to BHH providers to access the training curriculum developed by MaineCare?	This has not yet been determined.
113. Will MaineCare make all of these activities accessible	This level of detail is not yet available, but it is the intention of MaineCare to make this training accessible and available to providers.

and available for webinar/e-learning participation vs. expecting providers to travel long distances, thus negatively impacting access to service and driving unnecessary cost?	
RFA Process:	
114. Please provide a complete copy of the questionnaire for review in a standalone document to support review and preparation prior to inputting the information into Survey Monkey?	The stand-alone PDF is available on the BHH web page.
115. Question 12 has space for only five BHHO sites. What is the process for including more than five sites?	MaineCare will amend the application to include additional space.
116. Question 23 asks, "Does your agency have a partnership with at	Assuming you will be providing both the BHHO and the HHP components of the service, so the answer to the questions would be "yes".

least one Health Home Primary Care Practice." We are a Health Home Primary Care Practice with multiple sites. How should we answer this question?	
117. Question 24 asks us to indicate the number of primary care practices with which we plan to partner. Does this include our own health home sites, as well as health home sites of other organizations?	Yes.
118. Miscellaneous	
119. What is the estimated number of enrollees at the start and during the first year of the BHH by county, age and diagnoses?	While MaineCare has made some initial estimates on enrollees based on informal interest from provider organizations, we cannot provide a meaningful estimate of enrollment before the close of the application period.

120. What is the plan for unification of systems and simplification of data entry and collection of quality data?	MaineCare understands that this is a concern and will take this into account as we develop systems and supports for BHH.
121. What if any planning is being done regarding resolution of privacy and confidentiality issues that continue to inhibit collaboration efforts? The state can take a lead role in developing clear guidelines and a process to mediate and resolve differences between providers.	MaineCare has worked on these issues as part of the development and roll out of Stage A that it can share as part of the development process.
122. Does MaineCare intend to require that all Accountable Care Communities partner with all BHHs in their geographic regions?	
123. What is the motivation for a Mainecare recipient to choose this?	MaineCare members, including people who use community mental health services, have expressed frustration at the difficulty they encounter in accessing and maintaining relationships with primary care, in managing their mental and physical health care needs, and in the lack of integration across service systems. While the BHH may not be the right

	choice for everyone, many MaineCare members anticipate that this will help them better manage their care.

Appendix A
Staff Qualifications
Draft

(1) Psychiatric Consultant – shall be a psychiatrist who has current and valid licensure as a physician from the Maine Board of Licensure in Medicine, and who is certified by the American Board of Psychiatry and Neurology Psychiatric medication management or is eligible for examination by that Board as documented by written evidence from the Board, or has completed three years of post-graduate training in psychiatry approved by the Education Council of the American Medical Association and submits written evidence of the training; OR an advanced practice psychiatric and mental health registered nurse who is licensed as a nurse practitioner or clinical nurse specialist by the state of Maine, has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner, or clinical nurse specialist program, and is certified by the appropriate national certifying body; OR an organization licensed by the Department to provide medication management services pursuant to Chapter II, Section 65 of the MaineCare Benefits Manual.

The Psychiatric Consultant shall consult with the member and other BHHO and HHP professionals as necessary, and provide coordination of each member's psychiatric service and medication needs.

Under Section 92, the Psychiatric Consultant shall provide neither psychiatric services nor psychiatric medication services, nor shall the Psychiatric Consultant duplicate any other psychiatric services that may be necessary and provided through other sections of the MaineCare Benefits Manual.

(2) Nurse Care Manager – shall be a registered nurse, nurse practitioner, licensed practical nurse, or advance practice nurse, as defined by the Maine State Board of Nursing.

The Nurse Care Manager shall provide primary care consultation, psychiatric care consultation, and other Section 92 services as necessary, pursuant to the Plan of Care.

(3) Clinical Team Leader – shall be an independently licensed mental health professional, who may be a physician, physician's assistant, psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage

and family therapist, registered nurse, psychiatric nurse, advanced practice registered nurse, or an advanced practice psychiatric nurse; OR a person who was employed on August 1, 2009 as a case management supervisor under the former Section 13 of Chapter II of the MaineCare Benefits Manual. Such staff shall be considered qualified to serve as a Clinical Team Leader for purposes of this rule.

The Clinical Team Leader shall direct care management activities across the BHHO, provide supervision of Health Home Coordinators and Certified Intentional Peer Support Specialists, and ensure that the BHHO meets its requirements as a whole.

(4) Certified Intentional Peer Support Specialist (CIPSS) – is an individual who has completed the Maine Office of Substance Abuse and Mental Health Services curriculum for CIPSS and receives and maintains that certification. The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members. CIPSS for children's services is an individual who has completed the designated Maine Office of Child and Family Services curriculum for peer supports and receives and maintains that certification.

(5) Health Home Coordinator for Members with Serious Emotional Disturbance (SED) – shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR a who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR who has been employed since August 1, 2009 as a case manager providing services under Chapter II, Section 13 of the MaineCare Benefits Manual.

(6) Health Home Coordinator for Members with Serious and Persistent Mental Illness (SPMI) – shall be an individual who is certified by the Department as a Mental Health Rehabilitation Technician/Community (MHRT/C).

(7) Medical Consultant – shall be a physician licensed by the State of Maine to practice medicine or osteopathy, or a Certified Nurse Practitioner who is a registered nurse who meets all of the requirements of the licensing authority of the State of Maine to practice as a Certified Nurse Practitioner.

The Medical Consultant shall collaborate with other providers of BHHO services and the HHP (at least 4 hours/month) to select and implement evidence-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings.